

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07153

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Principio Furnace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 76 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town Principio Furnace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name War

3. (a) FULL NAME

Ella M. Anderson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Newton W. Anderson
 7. Birth date of deceased (mo., day, yr.) February 11, 1872 6.(c) If alive, give age 78 years
 8. AGE: Years 76 Months 5 Days 1 If less than one day
 hrs. min.

9. Birthplace Cecil Co., Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Aaron Blackson
 13. Birthplace New Jersey
 14. Maiden name Mary A. Mahan
 15. Birthplace Md.

16. Informant Newton W. Anderson
 Address Principio Furnace, Md.
 17. Burial Date thereof July 14, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Principio
 Location Principio Furnace, Md.
 18. Funeral director Lee A. Patterson & Son
 Address Perryville, Md.

19. July 14, 1948 Irene E. Langford
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1948
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 31, 1939 to July 12, 1948
 and that I last saw him alive on July 8
 Immediate cause of death Thrombosis
 DURATION 1 hr
 Due to Hypertension 10 yrs.
Arterio Sclerosis 12 yrs.
 Due to Partial hemiplegia 7 yrs.
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, pub'c place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. F. Magraw
Perryville, Md. M. D. or other
 Address Date signed 7/14/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

556

07154

Reg. Dist. No. 92

1. PLACE OF DEATH:

County CecilCity or town Elkton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:

Union HospitalHow long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Elkton
(If outside city or town limits, write RURAL and give nearest town)Street No. 132 W. High
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Clara E Biddle

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

October 17, 1879

8. AGE:

68 Years8 Months22 Days

If less than one day

hrs.

min.

9. Birthplace

Elkton, Cecil, Maryland
(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

FATHER

12. Name

Jacob Biddle

13. Birthplace

Cecil Co., Maryland

MOTHER

14. Maiden name

Elizabeth Touch

15. Birthplace

Elkton, Cecil, Maryland

16. Informant

Address

Hospital Record - Union Hospital, Elkton, Md

17. Burial

(Burial, cremation, or removal, Where?)

Date thereof

July 11, 1948
(month) (day) (year)

Cemetery or crematory

Elkton

Location

Elkton, Md

18. Funeral director

Address

H. P. Phipps
Elkton, Md

19. July 10, 1948

(Date rec'd by registrar)

J. H. Frazier
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 9, 1948 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1948 to July 9, 1948
and that I last saw him alive on July 9, 1948

Immediate cause of death

Uremia

DURATION

July 1 -

Due to

catarrh of bladder -

Due to

metastatic carcinoma of
bladder, spine with paralysis

Other conditions

2 bags and bladder
carcinoma of liver
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wilford H. Sprecher, M.D.
M. D. or other

Address

Elkton, Md

Date signed

July 9-48

RECEIVED

JUL 13 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
City or town Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
Hollingsworth Manor 226

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil
City or town Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 226 Hollingsworth Manor
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Boyce

3. (b) Social Security Number

4. Sex Male 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 1 / 48 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
2 hrs. min.

9. Birthplace Elkton, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Fred Smith

13. Birthplace W. Va

14. Maiden name Bessie Boyce

15. Birthplace W. Va

16. Informant Bessie Boyce

Address 226 Hollingsworth Manor Elkton, Md

17. Burial Date thereof July 2 / 48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md

18. Funeral director W. L. Pippin

Address Elkton, Md

19. July 2 1948 FR. Ingers
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1948 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1948 to July 1 1948 and that I last saw him alive on July 1, 1948

Immediate cause of death

Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

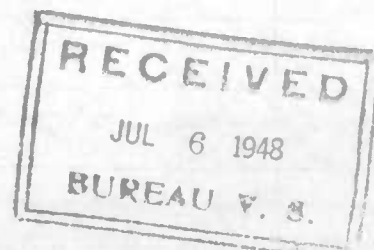
23. SIGNATURE Wm. H. Wechsner M. D. or other

Address 202 E. Union Date signed 7/2/48

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FORM No. G 11 JUL 27 1948

CERTIFICATE OF DEATH

07156

Reg. Dist. No. 96

1. PLACE OF DEATH:

County **Cecil**
City or town **Perry Point**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **1 yr. 1 mo. 1 day**
Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.
How long in hospital or institution? **1 yr. 4 mos. 0 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Baltimore**
City or town **Baltimore**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **139 North Broadway**
(If rural, give LOCATION)
2.(a) If veteran, name war **WW-I and PT**

3. (a) FULL NAME

BROWN, James O.

3. (b) Social Security Number

None

4. Sex **male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **Divorced**

6. (b) Name of husband or wife **Nelva E. Ranke**

7. Birth date of deceased (mo., day, yr.) **November 8, 1886** 6. (c) If alive, give age years

8. AGE: Years **61** Months **60** Days **8** If less than one day hrs. min.

9. Birthplace **Dublin, Kentucky**
(Town, county, and state)

10. Usual occupation **Retired soldier**

11. Industry or business

12. Name **Unknown - deceased**

13. Birthplace **Unknown**

14. Maiden name **Unknown - deceased**

15. Birthplace **Unknown**

16. Informant **Hospital records**

Address **VAH, Perry Point, Md.**

17. **Removal** Date thereof **July 21, 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Holy Redeemer**

Location **Baltimore, Md.**

18. Funeral director **Pennington & Son**

Address **Harre de Grace, Md.**

19. **July 27** 19 **48** **James E. Dunphy**
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 19, 1948** at **5:25 PM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 18, 1947** to **July 19, 1948** and that I last saw him alive on **July 19, 1948**

Immediate cause of death **Tuberculosis, pulmonary, chronic, far advanced, active** DURATION **Unknown**

Due to

Due to

Other conditions

Psychosis, due to arteriosclerosis **Unknown**
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature **J. E. Trolling**

23. SIGNATURE **A. E. TROLLINGER, M.D., Chief, Professional Svcs.**

Address **VAH, Perry Point, Md.** Date signed **7-20-48**

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07157

Reg. Dist. No. 90

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Rural Earlsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Pa. County..... Del.
 City or town..... Chester
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Abraham Browning

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Margaret M. Browning
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) Aug. 19, 1873
 8. AGE: Years 74 Months Days If less than one day
 9. Birthplace Upland, Pa.
 (Town, county, and state)
 10. Usual occupation Real Estate Sales-
 11. Industry or business

12. Name John Browning
 13. Birthplace Pa.
 14. Maiden name Martha Draper
 15. Birthplace England
 16. Informant Margaret M. Browning
 Address Rural Earlsville, Md
 17. Burial Date thereof July 6, 1948
 (Burial, cremation, or removal? Which?) (month) (day) (year)
 Cemetery or crematory Chester Pike Cemetery
 Location Chester, Pa.
 18. Funeral director Edward L. Shaw
 Address Millington, Md.
 19. July 5, 1948 Margaret M. Browning
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1948, at 3:30 a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1947, to July 3, 1948
 and that I last saw him alive on July 3, 1948
 Immediate cause of death Coronary occlusion
 DURATION 2 hours
 Due to Arterio-sclerosis - 20 yrs
 Due to
 Other conditions 1st Coronary occlusion 3 mos
 - 3 months ago
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Theodore J. Popowski, M.D.
 Address..... Greenville, Md. Date signed 7-5-48

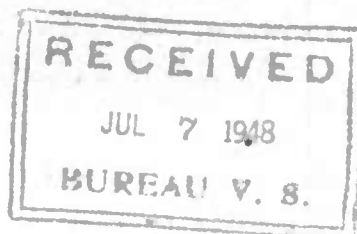
MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1947
44
1873



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

07158

96

1. PLACE OF DEATH:

County CECIL
 City or town PERRY POINT, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 days
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.
 How long in hospital or institution? 1 month 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Virginia County Warren
 City or town Front Royal
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1113 B Terrace, Chimney Field
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3. (a) FULL NAME

LOYD FRANKLIN CAMERON

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Bertha Cameron
 7. Birth date of deceased (mo., day, yr.) December 2, 1894 8.(c) If alive, give age years
 8. AGE: Years 53 Months 7 Days 14 hrs. min.

9. Birthplace Rileyville, Virginia
 (Town, county, and state)
 10. Usual occupation Quarryman
 11. Industry or business
 12. Name Benton Cameron
 13. Birthplace Page Co., Virginia
 14. Maiden name Bertha Mollie
 15. Birthplace Page Co., Virginia

16. Informant Hospital Records
 Address VAH, Perry Point, Maryland
 17. removal Date thereof 7-16-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Unknown
 Location Front Royal, Virginia
 18. Funeral director Wm. E. Edgington
 Address Havre de Grace, Maryland
 19. July 16 19 48 James E. Edgington
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 48 at 1:50 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 2 19 48 to July 16 19 48
 and that I last saw him alive on July 16 19 48
 Immediate cause of death
Failure of medullary centers
of brain
 Due to Thrombosis
 Due to Aneurysm of posterior inferior cerebellar artery, right
 Other conditions
 (Include pregnancy within 3 months of death)
 Major findings of operations Aneurysm and thrombosis of the posterior inferior cerebellar artery, right Date of op. 7/15/48
 Autopsy results No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Manner of injury Asphyxiation Injured at work?
 23. SIGNATURE A. E. TROLLINGER, M.D., Chf. Prof. Serv.
 M. D. or other
 Address VAH, Perry Point, Md. Date signed 7/16/48

RECEIVED

JUL 20 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County CecilCity or town Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CecilCity or town Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 308 N. St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret P. Clark

3. (b) Social Security Number

4. Sex F. 5. Color or race Wh. 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Wm D Clark7. Birth date of deceased (mo., day, yr.) May 26, 1867 6.(c) If alive, give age _____ years8. AGE: Years 81 Months 2 Days 1 If less than one day _____ hrs. _____ min.9. Birthplace Elkton, Md
(Town, county, and state)10. Usual Occupation at home

11. Industry or business

12. Name Michael Carr13. Birthplace Elkton, Md14. Maiden name Mary Patterson15. Birthplace 260 Ind16. Informant John ClarkAddress Elkton, Md17. Burial Date thereof July 30/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ElktonLocation Elkton, Md18. Funeral director H.W. PappasAddress Elkton, Md19. July 30, 1948 FR Frazier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1948 at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1948 to July 27, 1948
and that I last saw him alive on July 26, 1948Immediate cause of death Pneumonia, Broncho DURATION 11 23 48 as.Due to Renal FailureDue to PylonephritisOther conditions seizure

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

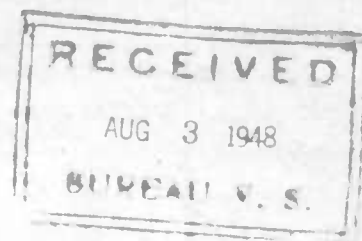
Means of injury _____ Injured at work? _____

23. SIGNATURE Arvin L. Wachsmann M.D.Address 202 E. Main St Date signed July 30, 1948
Elkton, Md.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

07160

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH

County Levittown
City or town Levittown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? sudden 10 yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind. County Levittown
City or town Levittown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 131 Collins Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Richard Leubbage.

3. (b) Social Security Number

4. Sex

M.

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 27, 1922
6. (c) If alive, give age..... years

8. AGE: Years 26 Months 4 Days 15 If less than one day..... hrs. min.

9. Birthplace

Dover, Del.
(Town, county, and state)

10. Usual occupation

Janitor

11. Industry or business

Tom. Carbage.

12. Name

Dover, Del.

13. Birthplace

Frederick Vincent

14. Maiden name

Dover, Del.

15. Birthplace

Chas Brown

16. Informant

131 Collins Ave. Levittown

17. Removal

(Burial, cremation, or removal. Which?) July 12/48
(month) (day) (year)

Cemetery or crematory

Whatoont Cemetery

Location

Dover, Del

18. Funeral director

W. H. Lippin

Address

Levittown, Ind

July 12 19 48

(Date rec'd by registrar)

J. R. Frager

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1948 at 11:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Drowned

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-11-48

Where did injury occur? Levittown Ind (City or town) Ind (State)

Injured at home, farm, industry, public place (where?) Fair Creek

Means of injury Fell off bank Injured at work? no

R. L. Jackson Medical Examiner

23. SIGNATURE James S. Smith M. D. or other

Address..... Date signed 7-12-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07161

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... **CECIL**
 City or town..... **PERRY POINT, MARYLAND**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **22 days**
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
 How long in hospital or institution? **Same as above**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Maryland** County.....
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **124 S. Jasper Street**
 (If rural, give LOCATION)
World War 1
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

RALPH DORAM

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife **Ida Doram**

7. Birth date of deceased (mo., day, yr.) **July 17, 1895**
 6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

53**0****13**

hrs.

min.

9. Birthplace..... **Centerville, Queen Annes, Md.**

(Town, county, and state)

10. Usual occupation

Unemployed

11. Industry or business

FATHER

12. Name..... **Unknown**13. Birthplace..... **Unknown**

MOTHER

14. Maiden name..... **Unknown**15. Birthplace..... **Unknown**16. Informant..... **Hospital Records'**

Address

VAH, Perry Point, Maryland17. **Removal**
(Burial, cremation, or removal. Which?)Date thereof **8/2/48**

Cemetery or crematory

Unknown Baltimore Natl

Location

Adolphus Halstead18. Funeral director..... **ADOLPHUS HALSTEAD**

Address

918 Druid Hill Ave., Baltimore, Md.

19. **Aug 2**..... 19 **48**
 (Date rec'd by Registrar)

Kene E. Dougherty
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **July 30th** 19 **48** at **1:30 P.** M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 8 19 **48** to **July 30** 19 **48**
 and that I last saw him alive on **July 30th** 19 **48**

Immediate cause of death.....

DURATION

Pneumonia, Bronchial, bilateral**72 hours**Due to **Peritonitis, diffuse****2 days**

Due to **Gangrene of Mesentery,**
cause undetermined

Unknown

Other conditions **Arteriosclerosis,**
generalized

Unknown

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... **Same as above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... **A.E. TROLLINGER, M.D., Chf. Prof. Serv.**

M. D. of other

Address..... **VAH, Perry Point, Md.** Date signed..... **8/2/48**

RECEIVED
JUN 8 1948
BUREAU V. O.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07162

94a
92

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

42

1

9

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

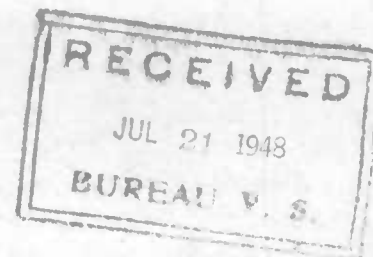
23. SIGNATURE

Address

Medical Examiner
for Cecil County

M. D. or other

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL
City or town PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs. 9 mos. 28 das.
Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1500 North Spring Street
(If rural, give LOCATION)
2.(a) If veteran, name war WW-II

3. (a) FULL NAME

RAYMOND J. GAVIN

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced
6.(b) Name of husband or wife --
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) January 15, 1917
8. AGE: Years 31 Months 6 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Shipyard Worker
11. Industry or business _____

12. Name Joseph Martin Gavin
13. Birthplace Baltimore, Md.
14. Maiden name Anna T. Thillhof
15. Birthplace Germany

16. Informant Hospital Records
Address VAH, Perry Point, Md.

17. Removal Date thereof 7/28/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Unknown

18. Funeral director E. I. FANNING & SON
Address Lafayette & Washington, Baltimore, Md.

19. July 28 19 48 James S. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27th 19 48 at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 29 19 48 to July 27th 19 48
and that I last saw him alive on July 27th 19 48

Immediate cause of death Electrocution DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/27/48

Where did injury occur? VA Hospital, Perry Point, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) VA Hospital

Means of injury Electricity Injured at work? Yes

23. SIGNATURE W. D. Jackson Medical Examiner

Address Rising Sun, Maryland Date signed 7/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 30 1948
WIDEWAT V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07164

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil
City or town... Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
Union Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Cecil

City or town... Elk Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Girl Hubbert

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1948

8. AGE: Years Months Days It less than one day
1 hrs. min.

9. Birthplace... Elkton Cecil Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Edward Carr Hubbert

13. Birthplace Elk Mills, Maryland

14. Maiden name Edith Louise Simpers

15. Birthplace Elkton, Maryland

16. Informant Edward Carr Hubbert

Address Elk Mills, Md

17. Burial Date thereof July 15-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cherry Hill, Maryland

Location Cherry Hill Md

18. Funeral director Henry Pippin

Address Elkton, Maryland

19. July 15-1948 HK Frazee
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1948 at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1948 to July 15 1948 and that I last saw her alive on July 15 1948

Immediate cause of death Congenital debility

Due to Premature delivery (6 1/2 mos gestation)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hubbert M. D. or other

Address Elkton Md Date signed 7/15/48

MARGIN RESERVED FOR BINDING

VS 415 9-45-18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 20 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil

City or town... Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo.

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Prince Georges

City or town... Beltsville
(If outside city or town limits, write RURAL and give nearest town)Street No... Md
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Jean Hughes

3. (b) Social Security Number

4. Sex 7 5. Color or race W 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife... George Bond Hughes

7. Birth date of deceased (mo., day, yr.) December 3, 1875 6. (c) If alive, give age... years

8. AGE: Years 72 Months 7 Days 6 If less than one day... hrs. min.

9. Birthplace... Belfast, Ireland
(Town, county, and state)

10. Usual occupation... at home

11. Industry or business

12. Name... James Robinson

13. Birthplace... England

14. Maiden name... Duke

15. Birthplace... Ireland

16. Informant... James W. Hughes (son)

Address... Elkton, Maryland

17. Burial Date thereof... July 12, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Fort Lincoln

Location... Washington DC

18. Funeral director... H. J. Frager

Address... 759 E Main St Elkton, Md

19. July 10, 1948 759 E Main St Elkton, Md

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 9, 1948 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6, 1948 to July 9, 1948 and that I last saw him alive on July 9, 1948

Immediate cause of death... Acute cardiac dilatation

Due to... Cardiac renal vascular

Due to... Diabetic mellitus

Diather conditions... (Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... M. D. or other

Address... Elkton, Md Date signed... 7/9/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 13 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07166

96

1. PLACE OF DEATH:

County CecilCity or town Principio Furnace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Principio Furnace
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran name war _____

3. (a) FULL NAME

Deborah Amelia Jackson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1862 6. (c) If alive, give age _____ years8. AGE: Years 85 Months 9 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Principio Furnace, Cecil, Md.
(Town, county, and state)10. Usual occupation Teacher11. Industry or business Music12. Name Alexander Jackson13. Birthplace Cecil Co., Md.14. Maiden name Mary Ann Burroughs15. Birthplace Cecil Co., Md.16. Informant Walter SimmonsAddress Principio Furnace, Md.17. Burial Date thereof Aug. 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St MarksLocation Perryville, Md. Rural18. Funeral director Lee A. Patterson & SonAddress Perryville, Md.19. July 21, 1948 Dr. E. S. Slaughter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1948 at 4 a. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1948 to July 31, 1948 and that I last saw him alive on July 30, 1948Immediate cause of death Cerebral embolism DURATION 7 daDue to General atheroma atheroma 10 yrb

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. F. Magraw M. D. or other _____Address Perryville, Md Date signed 7/31/48

MARGIN RESERVED FOR BINDING

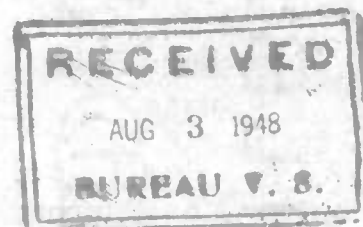
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2

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07167

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Levitt
 City or town Principio Furnace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 87 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind. County Levitt
 City or town Principio Furnace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Grace Lillian Jones

3. (b) Social Security Number

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Wm. Edward Jones

7. Birth date of deceased (mo., day, yr.) Dec 14 1878 6.(c) If alive, give age _____ years

8. AGE: Years 69 Months 6 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Ind.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Joseph O'Brien

13. Birthplace no information

14. Maiden name no information

15. Birthplace _____

16. Informant Wm. E. Jones

Address Fore de Grace Ind.

17. Burial Date thereof July 15, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Asbury

Location Post Hospital, Ind. Rural

18. Funeral director Lee A. Patterson & Son

Address Berryville, Ind.

19. July 14 19 48 Jane E. Dougherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 19 48 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Coronary Sclerosis DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

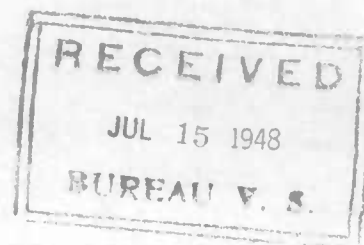
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Medical Examiner Ed Dodson M.D. Cecil County

23. SIGNATURE Rising Sun Ind. M. D. or other _____

Address _____ Date signed 7-13-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil
 City or town... Elctm
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 1/2 hours
 Hospital, institution, or street address where death occurred:
 Union Hospital
 How long in hospital or institution? 3 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Cecil
 City or town... Rural - Elctm
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Chesapeake Road RD 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ronald Jones

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) July 10, 1948
 8. AGE: Years Months Days If less than one day
 3 hrs. 30 min.

9. Birthplace Elctm Cecil County Maryland
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Robert Oliver Jones

13. Birthplace Elctm Maryland

14. Maiden name Hattie Anderson

15. Birthplace Fox Virginia

16. Informant Mrs. Hattie Jones

Address Elctm, RD 2 Md.

17. Burial Date thereof July 8, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Elctm

Location Elctm Md

18. Funeral director H. W. Pippin & Son Inc

Address Elctm, Md.

19. July 10, 1948 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1948, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10, 1948, to July 10, 1948

and that I last saw him alive on July 10, 1948

Immediate cause of death Prematurity

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. P. H. Anderson Jr. M.D.

Address Elctm, Md. Date signed 7/10/48

RECEIVED

JUL 13 1943

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... Cecil
City or town..... Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 23 days
Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Maryland
How long in hospital or institution?..... 1 yr. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Marys
City or town..... Oakley
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2. (a) If veteran, name war..... WW-I

3. (a) FULL NAME

JONES, WILLIAM AUGUSTUS

3. (b) Social Security Number

Unknown

4. Sex..... Male 5. Color or race..... Negro 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife..... --

7. Birth date of deceased (mo., day, yr.)..... August 10, 1896 6. (c) If alive, give age..... years

8. AGE: Years..... 51 Months..... 10 Days..... 24 If less than one day..... hrs. min.

9. Birthplace..... Washington, D.C.
(Town, county, and state)

10. Usual occupation..... Truck Driver

11. Industry or business..... --

12. Name..... Unknown
13. Birthplace.....

14. Maiden name..... Kate Jones
15. Birthplace..... Unknown

16. Informant..... Hospital Records
Address..... VA Hospital, Perry Point, Md.

17. Removal Date thereof..... 7 7 48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Arlington National Cemetery
Location..... Fort Myer, Virginia

18. Funeral director..... PENNINGTON & SON
Address..... Havre de Grace, Md.

19. July 7 19 48 Dr. E. R. Doughty
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 4th, 19 48, at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 11, 19 48, to July 4, 19 48
and that I last saw him alive on July 4, 19 48

Immediate cause of death..... Pneumonia, bronchial, bilateral DURATION..... 72 hrs.

Due to..... Abscess, pyogenic, right upper lobe Unknown

Due to..... --

Other conditions..... --

(Include pregnancy within 3 months of death)

Major findings of operations..... -- Date of op.....

Autopsy results..... Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE..... A. E. TROLLINGER M. D. or other
A. E. TROLLINGER, M.D., Chief, Professional Services
Address..... VA Hospital, Md. Date signed..... 7-6-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Shirley Ann Hiest

3. (b) Social Security Number

4. Sex.....
 5. Color or race.....
 6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....
 6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days.....
 If less than one day..... hrs..... min.

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....
 13. Birthplace.....

14. Maiden name.....
 15. Birthplace.....

16. Informant.....
 Address.....

17. Burial.....
 (Burial, cremation, or removal. Which?) Date thereof.....
 (month) (day) (year)

Cemetery or crematory.....
 Location.....

18. Funeral director.....
 Address.....

19. July 26, 1948.....
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 and that I last saw him..... alive on.....
 Immediate cause of death.....
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

Major findings of operations.....
 Date of op.

23. SIGNATURE.....
 Address.....
 Date signed.....

24. SIGNATURE.....
 Address.....
 Date signed.....

25. SIGNATURE.....
 Address.....
 Date signed.....

26. SIGNATURE.....
 Address.....
 Date signed.....

27. SIGNATURE.....
 Address.....
 Date signed.....

28. SIGNATURE.....
 Address.....
 Date signed.....

29. SIGNATURE.....
 Address.....
 Date signed.....

30. SIGNATURE.....
 Address.....
 Date signed.....

31. SIGNATURE.....
 Address.....
 Date signed.....

32. SIGNATURE.....
 Address.....
 Date signed.....

RECEIVED

JUL 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, INK UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07171

Reg. Dist. No.

96

1. PLACE OF DEATH:

County Cecil
 City or town Port Deposit
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
 City or town Port Deposit
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

STEPHEN DANIEL LAMM

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary A. Lamm
 6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) October 6, 1878

8. AGE: Years 69 Months 8 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Port Deposit, Cecil Co., Md.
 (Town, county, and state)

10. Usual occupation Mail Clerk

11. Industry or business Penn. Railroad Mail Service

12. Name John L. Lamm

13. Birthplace Port Deposit, Maryland

14. Maiden name Sarah R. Morrison

15. Birthplace Nottingham, Pennsylvania

16. Informant Mary A. Lamm

Address Port Deposit, Maryland

17. Burial Date thereof July 7, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hopewell Cemetery

Location Port Deposit, R.D., Maryland

18. Funeral director Lee A. Patterson & Son

Address Perryville, Maryland

19. July 17, 1948 Irma E. Daugherty
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1948 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27, 1942 to July 3, 1948
 and that I last saw him alive on July 3, 1948

Immediate cause of death _____ DURATION _____

Chronic Rheumatism 6 yrs.

Due to _____

Due to _____

Other conditions Arterio Sclerosis 10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

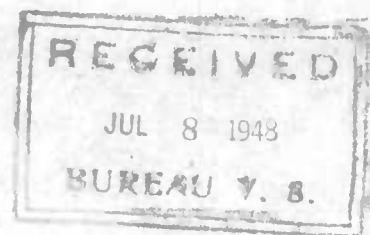
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B. J. Johnson, M.D.

M. D. or other _____

Address Port Deposit, Md. Date signed 7/6/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *92*

1. PLACE OF DEATH:

County *Cecil*

City or town *Elkton*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Union Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Cecil*

City or town *North East*
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

and living

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *July 22, 1948*

8. AGE: Years Months Days If less than one day
7 hrs. 29 min.

9. Birthplace *Elkton, Cecil, Maryland*
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name *William Rodney Lewis*

13. Birthplace *Cherry Hill, Md.*

MOTHER 14. Maiden name *Beatrice May Reynolds*

15. Birthplace *North East, Md.*

16. Informant *Mr. Rodney Lewis*

Address *North East, Md.*

17. *Burial* Date thereof *July 23/48*
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory *North East*

Location *North East, Md.*

18. Funeral director *H. W. Pippin & Son*

Address *Elkton, Md.*

19. *July 23* 19 *48*
(Date rec'd by registrar) Registrar *FR Frazier*

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 23* 19 *48* at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *July 20* 19 *48* to *July 23* 19 *48*

and that I last saw him alive on *July 20* 19 *48*

Immediate cause of death *Premature Birth* DURATION *Three*

Due to *Infection in mother*

Due to _____

Other conditions *Encephalocyst*

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____ Date of op. *July 20/48*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *W. C. P. Pippin & Son* M. D. or other

Address *North East, Md.* Date signed *July 23/48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 95

07173

93d

1. PLACE OF DEATH:

County Cecil Co.

City or town Liberty Grove Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 68

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland, County Cecil Co.

City or town Liberty Grove Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Elba W. Siddell

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife George Siddell

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov 7 1879

8. AGE: Years 68 Months 8 Days 12 hrs. _____ min. _____

9. Birthplace Liberty Grove Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Stephen F. Woodrow
13. Birthplace Liberty Grove Md.

14. Maiden name Elizabeth Bancroft
15. Birthplace Phila. Pa.

16. Informant Mrs. James Eschleman
Address Liberty Grove Md.

17. Burial Date thereof July 27 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hopewell
Location Port Deposit Md.

18. Funeral director J. E. Hosen
Address Prising Sun Md.

19. July 27 - 48 Registrar Tom Worthington
Date signed 7-27-48

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 19 48 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 19 47 to July 25 19 48
and that I last saw him/her alive on July 24 19 48

Immediate cause of death Cerebral Vascular
Accident
Due to Hypertensive Cardio
Vascular Disease

DURATION 3 months
years _____

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Michael S. H. M. D. or other _____
Address Port Deposit Md. Date signed 7-26-48

MARGIN RESERVED FOR BINDING

I

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 28 1948

BUREAU V. 9.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mrs. Lunn

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

191a

07174

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Union Hospital

How long in hospital or institution? 2 days

3. (a) FULL NAME

Julie Lunn

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Miller Lunn

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 29, 1894

8. AGE: Years 53 Months 5 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace New York
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Charles Wielke

13. Birthplace New York

14. Maiden name Emma M. Duf

15. Birthplace ?

16. Informant Miller Lunn

Address North East Rd 2 Md

17. Burial Date thereof July 22/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Augustine

Location St. Augustine Md

18. Funeral director Joseph Grant

Address North East Md.

19. July 22 19 48 JR Frazer
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
 City or town near North East
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R 22
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 19 48, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 19 48 to July 19 19 48 and that I last saw her alive on July 19 19 48

Immediate cause of death Cerebral Edema

Due to Chronic Interstitial nephritis

Due to Hypertension

Other conditions Aortic Sclerosis

General
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. Heberobach M.D.
 Address Elkton Md Date signed 7/19/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... Cecil
City or town..... Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 19 days
Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.
How long in hospital or institution?..... Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Virginia County..... Arlington
City or town..... Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 4203 N Pershing Drive, Apt. #1
(If rural, give LOCATION)
2.(a) If veteran, name war..... WW I

3. (a) FULL NAME

McBRIDE, Daniel D.

3. (b) Social Security Number

376-05-0519

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... Married
6.(b) Name of husband or wife..... Juanita Bernice McBride
7. Birth date of deceased (mo., day, yr.)..... Oct. 11, 1897
8. AGE: Years..... 50 Months..... 8 Days..... 25 If less than one day..... hrs. min.

9. Birthplace..... Kansas City, Missouri
(Town, county, and state)
10. Usual occupation..... Automotive serviceman
11. Industry or business

12. Name..... Unknown
13. Birthplace..... Unknown
14. Maiden name..... Unknown
15. Birthplace..... Unknown

16. Informant..... Hospital records
Address..... VA Hospital, Perry Point, Md.

17. Removal Date thereof..... July 7, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Arlington National Cemetery
Location..... Fort Myer, Virginia

18. Funeral director..... C.J. Ives Funeral Home
Address..... 2847 Wilson Blvd., Arlington, Va.

19. July 7 19 48 James E. Troller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 6, 19 48, at 8:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 17, 19 48, to July 6, 19 48
and that I last saw him alive on July 6, 19 48

Immediate cause of death..... General Paralysis of the Insane Over 20 yrs.
DURATION
Unknown

Due to.....
Due to.....

Other conditions..... 1. Pyelitis, left kidney;
2. Cystitis; 3. Adenoma, small, right
(Include pregnancy within 3 months of death) kidney

Major findings of operations.....
Date of op.....

Autopsy results..... Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

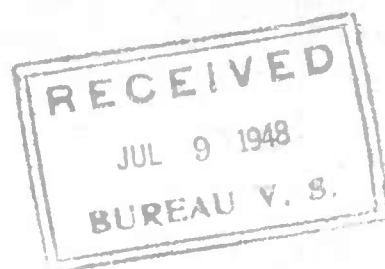
23. SIGNATURE..... A.E. Troller
A.E. TROLLER, M.D., Chief, Professional Svcs.
Address..... VAH, Perry Point, Md. Date signed..... 7-7-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Duration corrected 7/30/48, letter from Perry Pt. Hosp. AS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07176

131a

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 26 days

Hospital, institution, or street address where death occurred:

VA Hospital, Perry Point, Md.How long in hospital or institution? Since November 11, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 1731 Seaton Street, N.W.
(If rural, give LOCATION)2. (a) If veteran, name war WW-I

3. (a) FULL NAME

MURPHY, John Jackson

3. (b) Social Security Number

Unknown

4. Sex

male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Unknown

7. Birth date of deceased (mo., day, yr.)

June 28, 1886

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

6203

hrs.

min.

9. Birthplace Salem, Ala.
(Town, county, and state)10. Usual occupation Unknown

11. Industry or business

FATHER

12. Name Unknown13. Birthplace Unknown

MOTHER

14. Maiden name Unknown15. Birthplace Unknown16. Informant Hospital RecordsAddress VA Hospital, Perry Point, Md.17. Removal Date thereof July 3, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington National CemeteryLocation Fort Myer, Virginia

18. Funeral director

Address

PENNINGTON & SONHavre de Grace, Md.19. July 3 19 48 John E. Dougherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 19 48 at 6:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 19 48, to July 1, 19 48and that I last saw him alive on July 1, 19 48

Immediate cause of death

Pneumonia, bronchial, bilateral

DURATION

48 hrs.Due to Cardiovascular renal diseaseUnknown

Due to

Other conditions Coronary arteriosclerosis and generalized arteriosclerosis.
(Include pregnancy within 3 months of death)Unknown

severe

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

13. SIGNATURE

A.E. TROLLINGER, M.D., Chief, Professional ServicesAddress VAH, Perry Point, Md. Date signed 7-2-48

RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

193

07177

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town Elkton Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County CecilCity or town Chester
(If outside city or town limits, write RURAL and give nearest town)Street No. 704 E. 8th St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Edward Walter Paprocki

3. (b) Social Security Number

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

T. Birth date of deceased (mo., day, yr.) Sept 12 1916

6. (c) If alive, give age..... years

8. AGE:

Years

31

Months

10

Days

19

If less than one day

..... hrs, min.

9. Birthplace

Chester, Pa.
(Town, county, and state)

10. Usual occupation

Stage builder at Sea Ship

11. Industry or business

MOTHER FATHER

12. Name Walter Paprocki

13. Birthplace

Poland

14. Maiden name

Katherine Piziah

15. Birthplace

Poland

16. Informant

Address

704 E 8th St. Chester Pa.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Aug 4-48
(month) (day) (year)

Cemetery or crematory

St. Michaels

Location

Chester, Penna

18. Funeral director

Address

7th W. Whippin
Elkton Md

19. (Date rec'd by registrar)

Aug 2 1948JR Frazer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1948 at 130P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Electrocuted

.....

.....

.....

Due to.....

.....

Due to.....

.....

.....

Other conditions.....

.....

.....

.....

Major findings of operations.....

.....

.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

.....

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-31-48Where did injury occur Elkton Rural Cecil Md

(City or town) (County) (State)

Injured at home, farm, industry, public place, (where?) HomeMeans of injury Electric Wire Injured at work? yes

.....

23. SIGNATURE W. LeDochon MD Medical ExaminerAddress Mem 9 Sun Md for Cecil CountyDate signed 7-31-48

.....

RECEIVED

AUG 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07178

Reg. Dist. No. *92*

1. PLACE OF DEATH:

County.....*Elkton*
 City or town.....*Elkton*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*many years 60*
 Hospital, institution, or street address where death occurred:
135 Moffatt St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....*md.* County.....*lewis*
 City or town.....*Elkton*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *135 Moffatt St.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mamie Maorie Peterson

3. (b) Social Security Number

4. Sex.....*F* 5. Color or race.....*White* 6.(a) Single, married, widowed, or divorced.....*Widowed*

6.(b) Name of husband or wife.....*Leus John Peterson*
 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....*December 24, 1869*

8. AGE: Years.....*78* Months.....*6* Days.....*26* If less than one day..... hrs. min.

9. Birthplace.....*Brooklyn N.Y.*
 (Town, county, and state)

10. Usual occupation.....*at home*

11. Industry or business.....

12. Name.....*Anthony Carr*

13. Birthplace.....*Italy*

14. Maiden name.....*Rosa Archopoli*

15. Birthplace.....*Italy*

16. Informant.....*Mr Leus Peterson*

Address.....*Elkton, Md*

17. Burial, cremation, or removal. Which?.....*Burial* Date thereof.....*July 23 /48*
 (month) (day) (year)

Cemetery or crematory.....*Catholic*

Location.....*Elkton, Md*

18. Funeral director.....*W. Pippin*

Address.....*Elkton, Md*

19. *July 21* 19 *48*.....*FR Frazee*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*July 20* 19 *48*, at *3 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19..... to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....*Coronary* DURATION.....*sclerosis*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

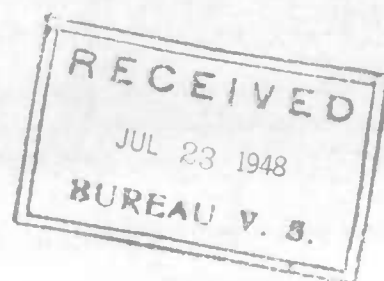
Accident, suicide, or homicide..... Date of.....?

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*W. Pippin* Medical Examiner.....*W. Pippin*
 Address.....*Elkton, Md* M. D. or other.....*W. Pippin*
 Date signed.....*7-20-48*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07179

92

1. PLACE OF DEATH:

County

City or town

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Ward No.

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

if less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

E.S.T.

20. DATE OF DEATH

19 48, at 8:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 June 19 48, to 6 July 19 48, and that I last saw her alive on 5th July 19 48.

Immediate cause of death

DURATION

coronary occlusion

2 weeks

Due to

arteriosclerosis of coronary arteries

Due to

Other conditions

chr cholelithiasis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07180

Reg. Dist. No. 96

1. PLACE OF DEATH:

County... **Cecil**
 City or town... **Perry Point, Md.**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **4 yrs. 6 mos. 28 days**
 Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.
 How long in hospital or institution? **5 yrs. 0 mos. 24 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... **Maryland** County... **Montgomery**
 City or town... **Silver Spring**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **719 Silver Spring Ave.**
 (If rural, give LOCATION)
 2. (a) If veteran, name war... **Peace time**

3. (a) FULL NAME

SCHAEFFER, Melvin L.

3. (b) Social Security Number

Unknown

4. Sex **male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **Married**
 6. (b) Name of husband or wife **Verna Mae Schaeffer**
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) **June 12, 1901**
 8. AGE: Years **47** Months **1** Days **0** If less than one day
 hrs. min.

9. Birthplace... **Quicksburg, Va.**
 (Town, county, and state)
 10. Usual occupation... **Mechanic**
 11. Industry or business...
 FATHER 12. Name... **Benjamin Schaeffer - deceased**
 13. Birthplace... **Virginia**
 MOTHER 14. Maiden name... **Gora Schaeffer**
 15. Birthplace... **Virginia**

16. Informant... **Hospital Records**
 Address... **VA Hospital, Perry Point, Md.**

17. **Removal** Date thereof **July 13, 1948**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... **Mt. Jackson Cemetery**
 Location... **Mt. Jackson, Virginia**
 18. Funeral director... **PENNINGTON & SON**
 Address... **Harve de Grace, Md.**

19. **July 13** 19 **48** **James E. Douglas**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... **July 12,** 19 **48** at **6:00 Pm**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 14, 19 **43** to **July 12,** 19 **48**
 and that I last saw him alive on **July 12,** 19 **48**

Immediate cause of death... **Uremia, uramic poisoning**
 DURATION **6 months**

Due to... **Glomerulonephritis** Unknown

Due to...
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op...

Autopsy results... **Same as above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... **A.E. TROLLINGER, M.D., Chief, Professional Services**
 Address... **VAH, Perry Point, Md.** Signed **7-13-48**

RECEIVED

JUL 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Elkton
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

R.D. 5 Elkton

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Cecil

City or town..... Rural near Elkton
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... R.D. 5, Md
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Becker Ernest Schirling

3. (b) Social Security Number

212-22-9093

4. Sex

M.

5. Color or race

Wh

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Dorothy Gertrude Schirling

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 28, 1907

8. AGE: Years Months Days If less than one day

40 7 17 hrs. min.

9. Birthplace

Perryville, Md
(Town, county, and state)

10. Usual occupation

Insurance

11. Industry or business

12. Name

George Schirling

13. Birthplace

Perryman, Md

14. Maiden name

Minnie Albrecht

15. Birthplace

Germany

16. Informant

Georgia Efron

Address

North East, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 18, 1948
(month) (day) (year)

Cemetery or crematory

Elkton

Location

Elkton, Md

18. Funeral director

H. W. Phipps

Address

Elkton, Md

19. July 17, 1948

(Date rec'd by registrar)

F. B. Frazer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 14, 1948, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1, 1948, to July 14, 1948

and that I last saw him alive on July 14, 1948

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. R. H. Andrews Jr.

Elkton, Md

Address

Date signed 7/15/48

M.D. or other

RECEIVED

JUL 20 1948

BUREAU V. S.

Evidence for correction
of birth date and age

shown on:

FILE No. G 117 AUG 27 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... **Cecil**
City or town..... **Perry Point,**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **18 days**
Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.
How long in hospital or institution? **Since June 21, 1948**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... **D.C.** County.....
City or town..... **Washington**
(If outside city or town limits, write RURAL and give nearest town)
Street No..... **109 K. Street, N.W.**
(If rural, give LOCATION)
2. (a) If veteran, name war **WW-I**

3. (a) FULL NAME

STONE, Richard

3. (b) Social Security Number

Unknown

4. Sex **male** 5. Color or race **Negro** 6. (a) Single, married, widowed, or divorced **Married**
6. (b) Name of husband or wife **Nellie M. Stone**
7. Birth date of deceased (mo., day, yr.) **Aug. 15, 1892** **June 16, 1888**
8. AGE: Years **60** **65** Months **11** **1** Days **3** **2** If less than one day **hrs.** **min.**

9. Birthplace..... **Masena, Georgia**
(Town, county, and state)
10. Usual occupation..... **Railroad Laborer**
11. Industry or business
12. Name..... **Unknown**
13. Birthplace..... **Unknown**
14. Maiden name..... **Unknown**
15. Birthplace..... **Unknown**

16. Informant..... **Hospital Records**
Address

17. **Burial** Date thereof..... **July 22, 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... **Arlington National Cemetery**
Fort Myer, Virginia
Location

18. Funeral director..... **PENNINGTON & SON**
Address **Harre de Grace, Md.**

19. (Date rec'd by registrar) **July 20** 19 **48** **Irene E. Langford** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **July 18,** 19 **48** at **10:17 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 1, 19 **48** to **July 18,** 19 **48**
and that I last saw him alive on **July 18,** 19 **48**

Immediate cause of death..... **Pneumonia, lobar** DURATION **30 hrs.**

Due to..... **Cardiovascular renal disease** **Unknown**

Due to.....

Other conditions **1. Cholecystitis, chronic**
2. Arteriosclerosis, generalized
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results..... **Same as above**
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE..... **A. E. TROLLINGER, M.D., Chief, Professional Svcs.**
Address..... **VAH, Perry Point, Md.** Date signed..... **7-19-48**

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07183

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 yrs. 9 mos. 11 days
 Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.
 How long in hospital or institution? 21 yrs. 9 mos. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County Allegheny
 City or town Pittsburgh
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1533 Broadway Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I

3. (a) FULL NAME

Strobatz, Joseph V.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) January 7, 1889
 8. AGE: Years 59 Months 6 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Pittsburgh, Pa.
 (Town, county, and state)
 10. Usual occupation Painter
 11. Industry or business _____
 12. Name Unknown
 13. Birthplace _____
 14. Maiden name _____
 15. Birthplace _____

16. Informant Hospital Records
 Address VA Hospital, Perry Point, Md.
 17. Removal Date thereof 7/26/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Unknown
Pittsburg, Pa.
 Location Pennington Road
 18. Funeral director Havre de Grace, Md.
 Address Havre de Grace, Md.
 19. July 25 19 Irma E. Daugherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 48, at 4:23A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13 19 26, to July 24 19 48and that I last saw him alive on July 24 19 48Immediate cause of death Pneumonia, bronchial, left DURATION 4-5 daysDue to Coronary sclerosis

Due to _____

Other conditions Atelectasis, right, post-operative, arteriosclerosis, generalized 33 days
 (Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Mens of injury _____ Injured at work? _____

23. SIGNATURE A. E. Trollinger

A. E. TROLLINGER, M. D., Chf. of Prof. Serv.

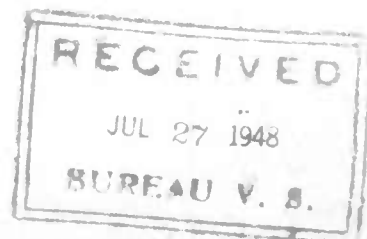
Address VAH, Perry Point, Md. Date signed 7/25/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 07184 91

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Jefferson Walworth

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

7. Birth date of deceased (mo., day, yr.).....
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.....

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....
 11. Industry or business.....

12. Name.....
 13. Birthplace.....
 14. Maiden name.....
 15. Birthplace.....

16. Informant.....
 Address.....

17. Burial..... Date thereof.....
 (Burial, cremation, or removal) Which?..... (month) (day) (year)

Cemetery or crematory.....
 Location.....

18. Funeral director.....
 Address.....

19. Date rec'd by registrar.....
 Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19..... at..... A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....
 Immediate cause of death.....

Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....
 Address.....

Medical Examiner.....
 M. D. or other.....

24. Date signed.....

RECEIVED

JUL 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0718596

1. PLACE OF DEATH:

County Cecil
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 yrs.
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME

WATSON

3. (b) Social Security Number

MARY

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife (dec.)

7. Birth date of deceased (mo., day, yr.) June 27, 1874

6.(c) If alive, give age — years

8. AGE: Years 74 Months 0 Days 12 If less than one day — hrs. — min.

9. Birthplace Cecil Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

12. Name Frank Niblock

13. Birthplace Cecil Co. Md.

14. Maiden name Elizabeth Niblock

15. Birthplace Cecil Co. Md.

16. Informant Ruth Niblock

Address 303 S. Washington, Harode Chase

17. Buried Date thereof 7/13/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Marks

Location Near Perryville, Md.

18. Funeral director Pennings & Son

Address Harode Chase, Md.

19. July 10 19. 48 Irene E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 July 19. 48, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19. 48, to July 19. 48

and that I last saw her alive on 9 July 19. 48

Immediate cause of death Uremia

DURATION

Due to Cerebral Hemorrhage (R)

- Apoplexy

Due to A.S. Hypertensive Ht.

Other conditions Disease

Malignant Hypertension
(Include pregnancy within 3 months of death)

Major findings of operations —

Antopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

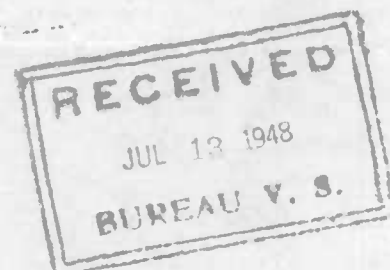
Signature W. H. Sadowsky MD

Address Perryville, Md. Date signed 9 July 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

07186

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil
City or town... Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0- hours & 30 min
Hospital, institution, or street address where death occurred:
Elkton Hospital
How long in hospital or institution? 3 1/2 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Pa. County... Chester
City or town... Franklin Township
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

W. Earl Wilkinson

3. (b) Social Security Number

4. Sex... M. 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Married

6. (b) Name of husband or wife... Catherine Williamson

7. Birth date of deceased (mo., day, yr.)... July 30 1924
6. (c) If alive, give age... 23 years

8. AGE: Years... 23 Months... 11 Days... 13
If less than one day... hrs. min.

9. Birthplace... West Grove, Pa.
(Town, county, and state)

10. Usual occupation... Milk Hauler.

11. Industry or business

12. Name... Wilmer E. Williamson

13. Birthplace... Humbleville, Pa.

14. Maiden name... Eda R. Williamson

15. Birthplace... Luttons Corner, Md.

16. Informant... Wilmer E. Williamson

Address... Landenberg, RDE Pa.

17. Burial Date thereof... July 16, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... St. Marys West Grove Pa.

Location... Cecil County Pa.

18. Funeral director... H. S. Homally & Son

Address... Kennett Square Pa.

19. July 13 1948 J. H. Strager
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 13 1948, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____, and that I last saw him _____ alive on _____ 19_____.

Immediate cause of death... 2nd & 3rd degree burns of torso & body.
Due to... 70% of body.

Due to... _____

Other conditions... _____

(Include pregnancy within 3 months of death)

Major findings of operations... _____

Date of op. _____

Autopsy results... _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of 7-12-48

Where did injury occur... Lemonsville Cecil Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)... Public Road.

Means of injury... Truck wrecked. Injured at work? yes.

23. SIGNATURE... R. L. Dodson M.D.
Medical Examiner for Cecil County

Address... Clearing Run Md. Date signed... 7-13-48

RECEIVED

JUL 20 1948

BUREAU V. S.

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07187

FILM No. G 115 JUL 20 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County.....**Cecil**
City or town.....**Perry Point**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....**6 yrs. 8 mos. 29 days**
Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.
How long in hospital or institution?.....**13 yrs. 0 mos. 7 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....**Kentucky** County.....**Jefferson**
City or town.....**Louisville**
(If outside city or town limits, write RURAL and give nearest town)
Street No.....**3614 W. Broadway**
(If rural, give LOCATION)
2.(a) If veteran, name war.....**WW-I**

3.(a) FULL NAME

WRIGHT, Earl B.

3.(b) Social Security Number

None

4. Sex.....**male**
5. Color or race.....**white**
6.(a) Single, married, widowed, or divorced.....**Married**

6.(b) Name of husband or wife.....**Mabel Rose Nesbitt**
6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....**Dec. 5, 1895**

8. AGE: Years.....**52** Months.....**50** Days.....**7** If less than one day..... hrs. min.

9. Birthplace.....**Frankfort, Kentucky**
(Town, county, and state)
10. Usual occupation.....**Policeman; Federal Prohibition Agent**

11. Industry or business

FATHER 12. Name.....**William Wright - deceased**
13. Birthplace.....**Virginia**
MOTHER 14. Maiden name.....**Cavilla Fitzpatrick - deceased**
15. Birthplace.....**Virginia**

16. Informant.....**Hospital Records**
Address.....**VA Hospital, Perry Point, Md.**

17. Removal.....**July 13, 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory.....**Unknown**
Location.....**Frankfort, Kentucky**

18. Funeral director.....**PENNINGTON & SON**
Address.....**Havre de Grace, Md.**

19. **July 13, 1948**
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**July 12, 1948** at **1:10 PM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 13, 1941 to **July 12, 1948**
and that I last saw him alive on **July 12, 1948**

Immediate cause of death.....**Tuberculosis, pulmonary, chronic, far advanced**
DURATION.....**Unknown**

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....

Autopsy results.....**Same as above**
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE.....**A.E. TROLLINGER, M.D., Chief, Professional Services**
Address.....**VAH, Perry Point, Md.** Date signed.....**7-13-48**

MARGIN RESERVED FOR BINDING

9-43-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 15 1948

BUREAU V. S.